December 5, 2013

VIA ELECTRONIC DELIVERY

Marlene H. Dortch, Secretary
Federal Communications Division
445 W 12th St. SW
Washington, DC 20554

Re: Impact and Adverse Outcomes of non-rural provider ineligibility on state led HCF consortia
WC Docket No: 06-20)

Madam Secretary:

In accordance with Section 1.1206 of the Commission's rules, 47 C.F.R. 1.1206, we hereby provide notice of oral ex parte communication during the above captioned meeting. On Monday, December 2, 2013, Kim Klupenger of OCHIN, Inc. and the Oregon Health Network, dba OCHIN, Inc., Ed Bostick and Rob Jenkins of the Colorado Telehealth Network and, Eric Brown and Denise Jurca of the California Telehealth Network met with Kim Scardino, Chief of the Telecommunications Access Policy Division, Linda Oliver, Deputy Chief of the Telecommunications Access Policy Division, Matt Quinn, director of healthcare initiatives and, Steve Rowings and Garnet Hanely, attorney advisors to the FCC. This meeting was held by request of the undersigned in reference to the determination that non-rural providers would be excluded from Healthcare Connect Fund (HCF) eligibility. Such determinations run counter to the spirit of the HCF order and the triple aim of healthcare both of which are central to the objectives of this program.

The key topics of discussion are as follows:

- **Oregon Health Network dba OCHIN:**
    - Oregon Health Network dba OCHIN discussed the significant financial impact on the consortium leader for the recruitment, planning and deployment of sites that were considered previously eligible as consortium leader receives no support for administrative tasks. This lack of support coupled with the administrative burden of filing appeals based on untimely eligibility determinations, amounts to a significant and unanticipated financial burden on consortia;
    - Oregon Health Network dba OCHIN emphasized that the fear of drawing down the Universal Services Fund is unfounded at this time as all forecasted drawdowns fall well short of the $400 million annual USF cap;
    - Oregon Health Network dba OCHIN pointed out that USAC resources provided to consortia lack the expertise and experience to correctly and efficiently guide consortium leaders though the complexities of the HCF order and its operationalization.

- Oregon Health Network dba OCHIN requested that determinations run counter to the language contained in paragraphs 214-215 of the HCF order. The determination of ineligibility of sites is counter to the language contained in these paragraphs and the eligibility sections (¶59-60) of the HCF order.

- **California Telehealth Network (CTN):**

  - California Telehealth Network expressed that the determination that non-rural health care providers are ineligible adds a level of unnecessary complexity to the HCF order which is counter to the stated goals to simplify HCF administration to encourage broader adoption among safety net providers thereby expanding access to health care services.

  - California Telehealth Network conferred with its USAC contacts prior to submitting the HCF paperwork for the 29 non rural clinics that have been denied and had been advised that eligibility would follow the same practices used under RHCPP. Based on this guidance, CTN assured these healthcare providers that they would be HCF eligible. Denial of these entities negatively impacts CTN's credibility and creates unnecessary HCF administrative complexity to determine site eligibility.

  - California Telehealth Network believes that the decision to deny grandfathering of previously eligible RHCPP urban healthcare entities that had not received RHCPP Funding Commitment Letters (FCL's) by the date of the HCF order on December 12, 2012 was a decision that was not clearly communicated to consortium leaders. CTN did not submit RHCPP funding requests prior to December 12th based on guidance from USAC staff to wait until pending CTN site substitutions and other vendor related administrative issues were resolved to minimize the administrative workload. Had the FCC or USAC advised CTN of the deadline prior to December 12th, CTN could have taken the appropriate action to comply.

  - California Telehealth Network reiterated that the decision to change eligibility status for non rural healthcare entities without prior notification compromises consortia financial sustainability planning. Based on previous eligibility practices CTN's operating budget and long term sustainability models are built on a 50%/50% mix of non rural and rural health care providers. The decision to change eligibility requirements negatively impacts CTN's sustainability efforts by at least $1,500 per year per site. The initial denial of 29 sites has a negative net contribution impact to CTN of over $40,000 per year. As indicated in CTN's comments during the HCF rulemaking, statewide networks need the financial, specialty care and other resources from non rural communities to help cross subsidize the cost of providing services to rural areas. Denying non rural healthcare entities participation makes sustainability of statewide networks more difficult.

  - California Telehealth Network requests, along with the other consortia present, an understanding to the source of this change and explanation of why the original understanding of eligibility has changed.

- California Telehealth Network believes that ambiguity in eligibility criteria, particularly the 12/12 FCL requirement, and untimely eligibility determinations will result in the exclusion of sites that actually champion Telehealth adoption. As an example, Oakland Children's Hospital (OCH) as a non rural health care entity has been an active participant in the RHCPP as part of the CTN consortia. OCH has expressed interest in providing badly needed telemedicine pediatric specialty care to other CTN clinics and has applied for HCF eligibility at 9 additional locations which have now been denied. Denying eligibility to these sites conflicts with the stated commitment to grandfather RHCPP health care entities and will limit specialty care resources made available to other rural and non rural locations. Ironically, previous FCC Chairman Genachowski made the announcement of the initial CTN RHCPP disbursements in a media event at OCN.

- **Colorado Telehealth Network:**

  - Colorado Telehealth Network reported that these eligibility determinations are the result of contradictory information provided to consortium leaders by USAC personnel.

  - Colorado Telehealth Network pointed out that individual sectors are the foundational components of the healthcare continuum. The Colorado Telehealth Network has the provision of truly integrated, meaning involving all components of the healthcare continuum regardless of locality, care as its central to its mission. When individual components are arbitrarily targeted and removed from this program, it compromises the foundation on which the continuum is built thereby degrading it to a fraction of its true potential.

  - Colorado Telehealth Network emphasized that as stated by USAC and the FCC, the intention is to eventually collect data on how consortiums are being utilized for care delivery. When sectors of care are arbitrarily removed from this reporting scheme due to non-rural locality, a large sector of the neediest patient populations are excluded from this data set as a result. Therefore, any reporting on any data collected on a portion or incomplete sample of the care continuum would be incomplete and of lessened value than a truly complete data set that encompasses all aspects of care delivered across the continuum regardless of provider location.

  - Colorado Telehealth Network believes that loss of non-rural providers results in a loss of value for networks as rural and non-rural providers benefit from connectivity. Further, non-rural providers don't necessarily have the financial wherewithal to absorb the cost of lost subsidy and non-rural locality is not an accurate indicator of a provider's patient base (example: Stout Street Clinic, Denver, CO.)

While the issues noted above have been points of contention for our consortia at various points over the past months, we would like to collectively recognize Don Lewis of the Universal Services Administrative Company for his wisdom, leadership and, pragmatism. Don's perspective and expertise is something each of our states consistently looks to as we continue our work as consortium leaders. As such, this group would like to formally recognize for the record Don's unwavering commitment to this program and his value as a leader to our consortia.

In conclusion, the undersigned collectively and respectfully request a reversal of ineligible sites that were the product of the issues state above. Additionally, this contingent respectfully requests that non-rural clinics be allowed to participate as a part of consortium applications per the HCF order as written. As stated above and based upon evidence-based forecasting, it is very unlikely that the HCF fund would reach its $400 million annual cap and therefore, eligibility determinations based on the fear of exhausting the fund are unfounded and should not be a determining factor in limiting provider participation particularly as part of consortium applications.

Respectfully Submitted,

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Attachments:
Colorado Telehealth Network Prepared Letter
Colorado Telehealth Network information slides
Colorado Telehealth Network Map

12/2/2013

VIA HAND DELIVERY

Linda Oliver, Deputy Division Chief
Federal Communications Commission
Wireline Competition Bureau
Telecommunications Access Policy Division
445 12th Street SW
Washington, DC 20554

Re: Impact and Outcomes of non-rural provider ineligibility on Colorado Telehealth Network (HCP#: 17212)

Dear Deputy Division Chief Oliver

The Colorado Telehealth Network was built and deployed in 2009-2010 with 201 original member connections as a part of the FCC's Rural Healthcare Pilot Program (RHCPP) though; CTN can trace its beginnings to the mid-1990s. Through a $4.6M award ($3.2M recurring support/$1.4M non-recurring support) to the Colorado Hospital Association to create Colorado Healthcare Connections (CHCC) and a $5M award ($3.9M recurring support/$1.08M non-recurring support) to the Colorado Behavioral Health Council to create Rocky Mountain Health Net (RMHN), CTN's formative iteration was realized. As a result, CTN has been responsible for putting in place a healthcare broadband infrastructure that is foundational to realizing the triple aim of healthcare both statewide and on a national level by providing the technological framework for improving access to quality healthcare at reduced costs, improving patient outcomes and increasing efforts surrounding coordinator care.

At the issuance of the Healthcare Connect Fund Order (FCC 12-150), CHCC and RMHN consolidated to form the Colorado Telehealth Network as it is currently realized. At present, the Colorado Telehealth Network (CTN) is a 195 connection, single vendor network spanning the state's 104,000 square miles. Located in 63 of 64 counties, CTN provides the state's healthcare broadband infrastructure for health care providers spanning the care spectrum from physical health, mental health, FQHCs to health systems and, safety net clinics. As such, the interconnectivity between non-rural and rurally located care centers that CTN provides has become a critical backbone for realizing the utilization of connectivity for care delivery. As noted by the FCC in the final rule and order for the Healthcare Connect Fund (HCF), the inclusion of non-rural healthcare providers has proven to be a foundational element in building viable networks that can be leveraged for care delivery. Networks like CTN, comprised of both rural and non-rural providers are critical in advancing national healthcare, economic and workforce development aims on both the Colorado, as well as, national levels. Providers located in non-rural areas represent critical connections for telehealth networks like CTN, as it is rural sites that often look to engage non-rural providers who specialize in areas of care not locally available to rural providers. The loss of rural/non-rural interconnectivity like the variety that CTN currently possesses, jeopardizes the overall value and sustainability of consortium leader networks like CTN.

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While consortium sustainability has been a key focus for CTN, arriving at a viable and sustainable revenue generating model has been a challenge. For much of its life, CTN has relied on member assessments levied by both the Colorado Hospital Association and Colorado Behavioral Health Council, foundation grants and community donations to sustain its administrative operations. However, due in part to the very narrow operating margins inherent in the reliance on grants, donations, and assessments as primary sources of revenue, CTN has reconfigured its approach with a focus not just on sustaining operations but in becoming a sustainable operation. Therefore, CTN has developed several product lines to complement tiered service levels that will be offered in the second iteration of CTN's network design known as CTN2. New service lines and tiered offerings, coupled with a service fee for existing and new member sites stratified by bandwidth, CTN has found itself in a position of growth over the past 6 months[1].

This growth has made sustainability a primary focus as we have grown from 2.5 full time employees to a team of 5 full time employees all dedicated to the operation of the CTN consortium. With the increase in payroll that accompanies increased staffing levels, CTN has seen its overhead grow accordingly. It is therefore essential that the CTN network grow as the loss of even a single site represents a real financial impact for CTN and its sustainability efforts.

As of November of 2013, while operating with very narrow margins, CTN provides customized and personalized service to 195 USAC funded member connections that represent roughly 81 providers across the care continuum in Colorado. CTN provides this service to members with a total annual budget of roughly $712,000 to provide the following services:

- FCC/USAC program management services: eligibility determination assistance, assistance with obtaining funding, RFP management/scoring, invoicing/subsidy drawdown and reconciliation, form submission
- Consortia leadership: site/service substitutions, site additions, technical support, membership support, billing support, appeal drafting and submission (as needed)
- Oversight of technical trouble shooting process-
- Coordination of both routine and emergency technical assistance
- Management of single service provider in all matters from site development, site preparation, deployment, billing and technical assistance
- Provide on-call customer service for member connections as CTN acts as the point of contact between members and service provider
- Statewide outreach, education and advocacy
- National outreach, education and sharing of best practices with other statewide networks
- Facilitate collaboration between members
- Facilitate collaboration with other HIE/HIT organizations around the state.

[1] It is important to note that many of CTN's non-rural sites are disproportionately supporting CTN operations and, by proxy, its rural members as our non-rural connections operate at higher bandwidths and thus pay a higher percentage of the fees on which CTN hinges its sustainability.

Based on CTN's understanding of the HCF as written which, includes non-rural provider sites as eligible for funding as part of consortia applications (HCF Order, para. 6), CTN anticipates bringing on 200 new connections, a majority of which will be rural, by the end of 2015 thereby increasing the size and connectivity potential of the CTN network by 100%. This goal of connecting an additional 200 safety net sites to the existing network is part of Governor Hickenlooper's public health agenda to achieve fair and equitable health care delivery. Plans are underway to incorporate these connections as key infrastructure necessary in providing care to an additional 235,000 citizens that are being added to the state Medicaid program. Thus, in partnership with the state-designated health information exchange (CORHIO) and the western slope regional health information exchange (Quality Health Network) and in partial response to the Affordable Care Act requirements and for meaningful use compliance, Colorado's broadband network functionality will provide critical support to undergird the state's newly formed health insurance exchange and Colorado's "All Payer's Claims Database". All these interdependent parts of the healthcare mosaic ride on one seamless, interoperable, secure, reliable and subsidized high speed data and image exchange network.

However, HCF subsidy is not adequate to fully fund this vision for fair and equitable healthcare delivery. It will take predictable program guidance from USAC from which long-term plans followed by long-term investments will be made. CTN's revenue structure is rooted primarily upon current and new membership fees, with additional product lines representing some promising new revenue streams in the coming months/years. While CTN weathers this time of transition, CTN will rely heavily on member's fees which are supported disproportionately by non-rural hospitals and health centers in non-rural areas. Without these current non-rural connections and the new non-rural connections CTN anticipated adding to the network in 2014 and 2015, the bulk of financial responsibility will shift to rural members which would make participation in CTN financially prohibitive.

Outside of the financial implications inherent in preventing new non-rural sites from joining CTN as members of consortia and obtaining HCF funding, the loss of the potential to add non-rural sites, who possess the specialist-centered service lines that rural locations simply do not, CTN rapidly loses the value it presents to care providers currently (HCF Order paras. 54, 60).

CTN, through the Colorado Hospital Association and Colorado Behavioral Health Council, strongly advocated for and supported the final HCF rule and order and has proceeded in network planning and deployment accordingly. CTN has based its strategic planning, business model and outreach and marketing efforts on the management of the HCF order and the potential growth for telehealth it represents across the country if implemented as written and approved. The seemingly recent determination that non-rural sites will not be allowed to participate where once considered eligible inserts obstacles to eligibility and network growth that were not a factor in the RHCPP. Accordingly, this unplanned for change in clarification from the initial guidance of the HCF order has resulted in an unanticipated administrative burden on CTN. We have found this is no less true for our colleagues in other states. Additionally, administrative turnover at USAC has left consortiums with USAC resources on the national level that lack experience and expertise that was provided during the RHCPP.

CTN and consortia in other states have indicated that there is some concern being expressed via the FCC about potential exhaustion of the $400M universal service fund HCF annual cap. While CTN is sensitive to this concern, based on network cost projections forecasted by CTN

and colleague networks, we find this concern to be unfounded at this time based on network cost data and the average of most conservative install costs and monthly recurring costs. Though CTN has prepared its own forecast, we find the forecast prepared by the Oregon Health Network to present the most complete picture of national drawdowns and therefore respectfully present it below.

Forecast across all 52 projects (Figures Provided by Oregon Health Network)

"Annual national average re-occurring cost for non-rural "non-rural" clinics at 65% subsidy:

Annual national re-occurring cost @ 65%	$14,775
Number of projects	52
Average number of non-rural "non-rural" clinics per project	19
Total (number of existing projects multiplied by average number of non-rural "non-rural" clinics)	988
Annual national re-occurring cost for non-rural clinics	**$14,598,038**

Annual national average of all other sites (rural, non-non-rural):

Average number of all other sites per project (rural, non-non-rural)	200
Number of projects	52
Total (number of existing projects multiplied by average number of other sites (rural, non-non-rural)	10,400
Annual national cost of all other sites (rural, non-non-rural)	**$153,663,554.20**

Annual national average install of non-rural, "non-rural" clinics:

Average annual install	$6,876
Total new non-rural, "non-rural" clinics forecasted per project	100
Number of projects	52
Total (number of existing projects multiplied by average number of new non-rural site installs)	5,200
Annual national cost of all new site installs for non-rural, "non-rural" clinics	**$35,754,414.58**

Grand Total Forecasted Cost at 200 sites per project, 52 projects, and 100 new sites per project: $189,417,968.78

> Given the above breakdown, including the national average of both installation and monthly reoccurring costs for both existing and new sites, rural and non-rural, the FCC would not exceed the annual cap of the [fund]."

There is little doubt that the RHCPP project has been one of great success for Colorado. Based on the level of attrition from RHCPP to HCF, which was just under 3%, CTN has clearly demonstrated a value for its members. Over the course of the pilot project, CTN has overseen the installation of broadband infrastructure where previously there was none available. Because of this, our rural members have the freedom to collaborate amongst one another via the CTN network in ways not previously thought possible. For example, North Colorado Medical Center and Yuma District Hospital, two members separated by roughly 120 miles, have leveraged their CTN connections into a viable Teleneurology service. Additionally, the CTN network has allowed health systems, like Valley-Wide Health Systems who connects 14 sites to CTN's network, to provide better coordinated care across its 15-county, 24,000 square mile service area.

Initially, CTN was granted eligibility for 190 sites (5 ineligible sites participating as consortium members paying "fair share") at a total annual cost of $11,679,004.02 of which $7,591,352.61 is eligible for subsidy. To obtain this funding commitment, CTN has essentially allocated the entirety of its resource pool. Therefore, it would not be unfair to estimate that CTN has allocated 80-85% of its total operating resources to support these efforts.

In light of these challenges and the impact on our consortium by the decision to exclude non-rural providers, CTN intends to take the following measures in collaboration with our colleagues in the western region and nationally. First, we will engage our state's congressional delegation to inquire with both the FCC and USAC regarding the secondary review of eligibility determinations. It is our hope that our congressional delegation can articulate the importance of standing behind original eligibility determinations and refraining from making unanticipated changes to the HCF program and Order. Additionally, we will communicate to our national representatives, along with our sister networks in other states, to garner their support and reinforce the importance of non-rural care provider participation in telehealth networks. Further, Colorado will be engaging the collective advocacy of both the Colorado Hospital Association and the Colorado Behavioral Health Council to help reinforce this as an issue of critical importance, not only for Colorado, but all states. Finally, CTN has formally appealed USAC rulings on non-rural site eligibility as it specifically appeals to two CTN members whose eligibility was abruptly reversed. This appeal was filed directly with the FCC by the assistant project coordinator of CTN on 11/22/13.

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Providing Colorado's Health Care Broadband Infrastructure

In light of the impact stated above, CTN respectfully requests that the spirit and the letter of the HCF order, as it is written, be the understanding for non-rural provider inclusion in HCF funded activities. The notion that non-rural Health Clinics are ineligible contradicts HCF Order and FAQs provided for order clarity (HCF Order, paras. 57-61; HCF FAQs, paras. 9-12).

Sincerely,

Ed Bostick

Ed Bostick
Executive Director
Colorado Telehealth Network

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CTN
Colorado Telehealth Network
Providing Colorado's Health Care Broadband Infrastructure

Colorado Telehealth Network
Project Snapshot · December 2013

CTN
Colorado Telehealth Network
Providing Colorado's Health Care Broadband Infrastructure

Colorado Telehealth Network: RHCPP

Partnership between Colorado Hospital Association (CHA) and Colorado Behavioral Health Council (CBHC)

Total Award:

$4.6M award CHA to create Colorado Healthcare Connections (CHCC)
$5M award CBHC to create Rocky Mountain Health Net (RMHN)
$1M "Bridge" Funding

Connected 201 health care providers across state of Colorado

Approx. 95% drawdown on RHCPP funds/5% remaining bridge funds

67% of RHCPP connections transitioned to HCF on 7/1/13 (very few sites relying on RHCPP/Bridge Funding

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Colorado Telehealth Network: HCF

Consolidated CHCC and RMHN to formally create Colorado Telehealth Network (CTN)

Total Award:
$7.5M/year (Deployed sites on 7/1/13; not billing – FCL 1/1/14)
Forecasted drawdown: $22.5M/3 years

195 sites across behavioral and physical care providers

200 additional sites added by end of 2015

CTN
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Colorado Telehealth Network: HCF Operations

Expanded staff from 2.5 FTE to 5 FTE

Operations expenses (2014 figures are estimates):
Staffing: $612,000/year

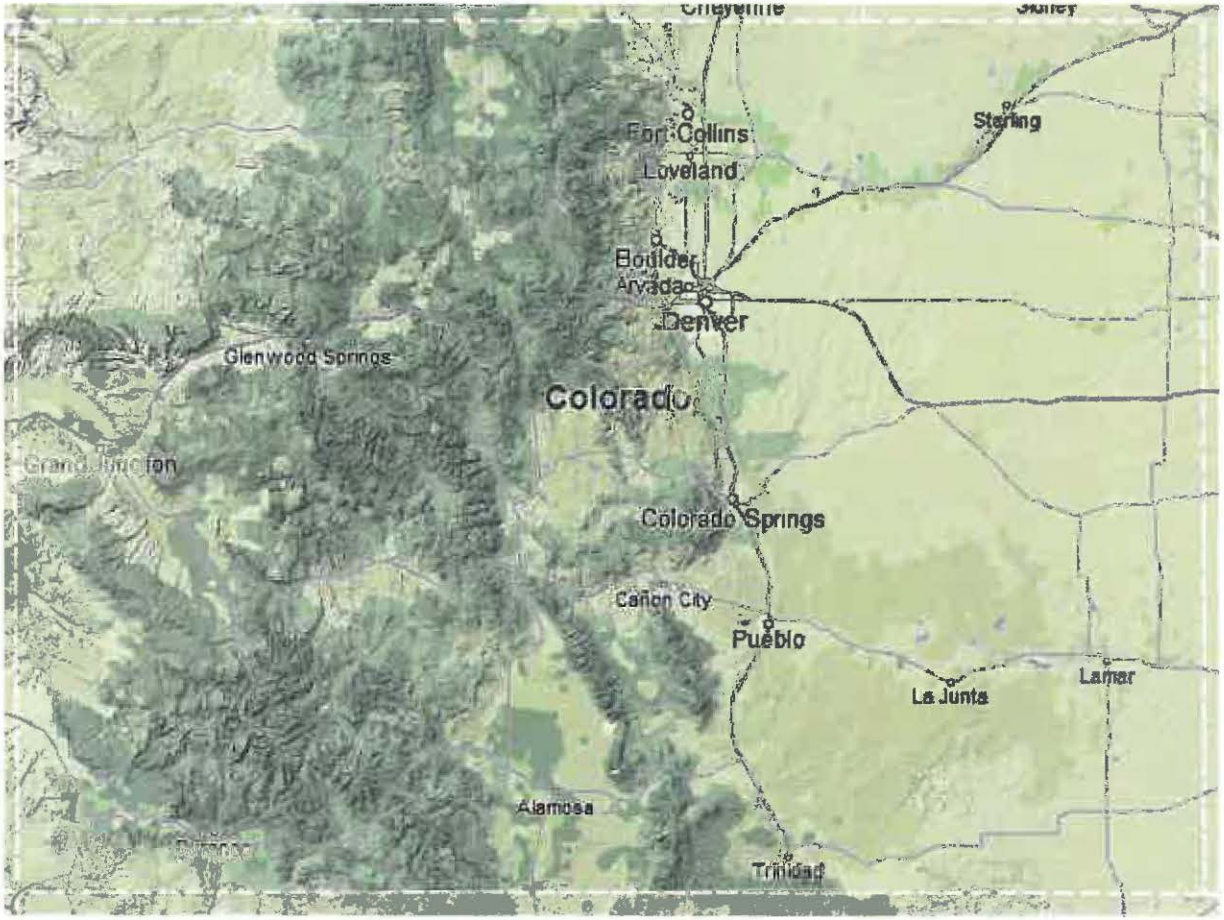
Overhead: $115,000/year

Tax obligations: $20,000/year

Total: $747,000/year

Total support outside of CTN: $478,000 ($-268,287.00 annual operational shortfall)

Colorado Telehealth Network (CTN)

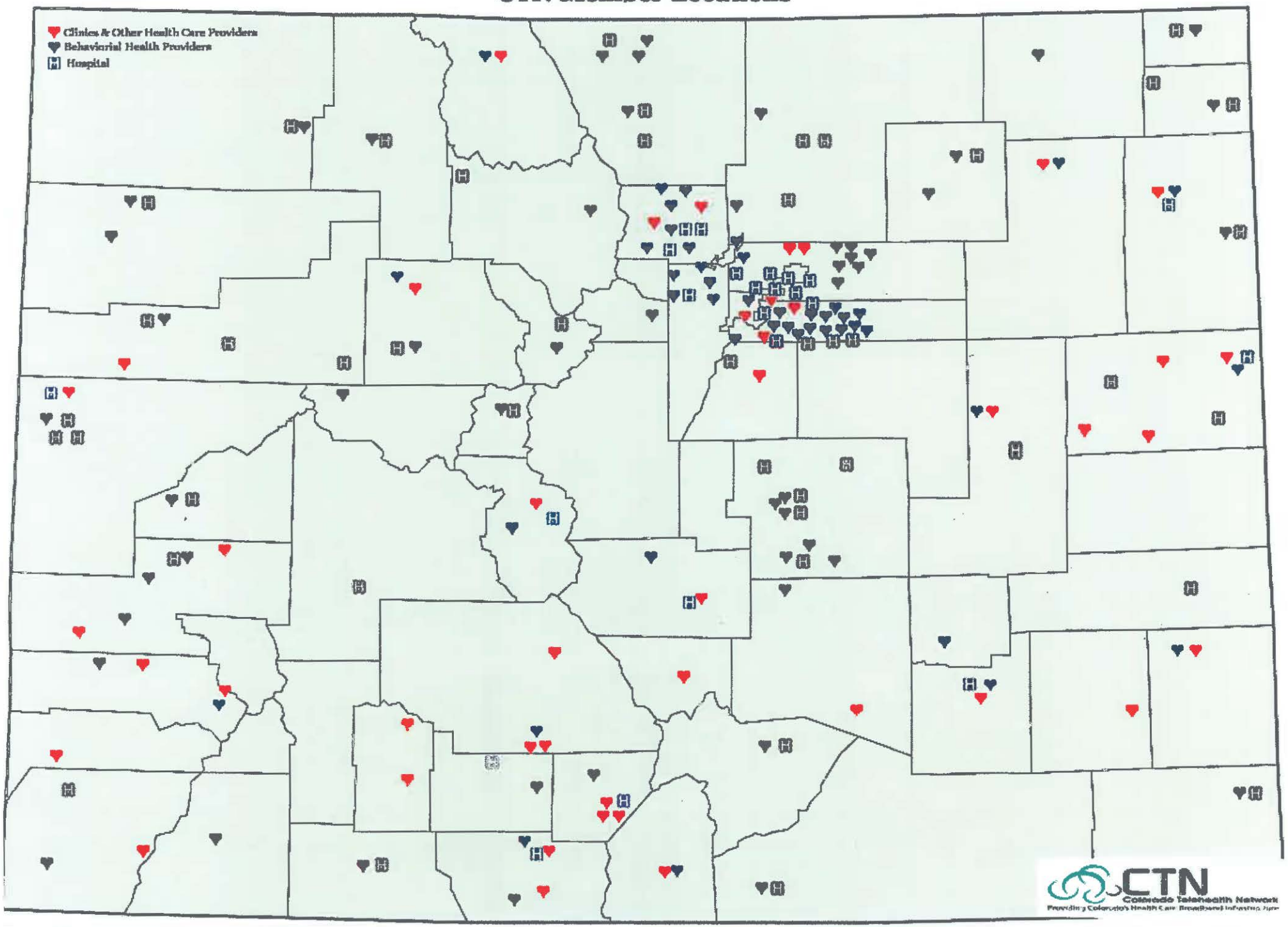


Colorado: 104,000 Square Miles

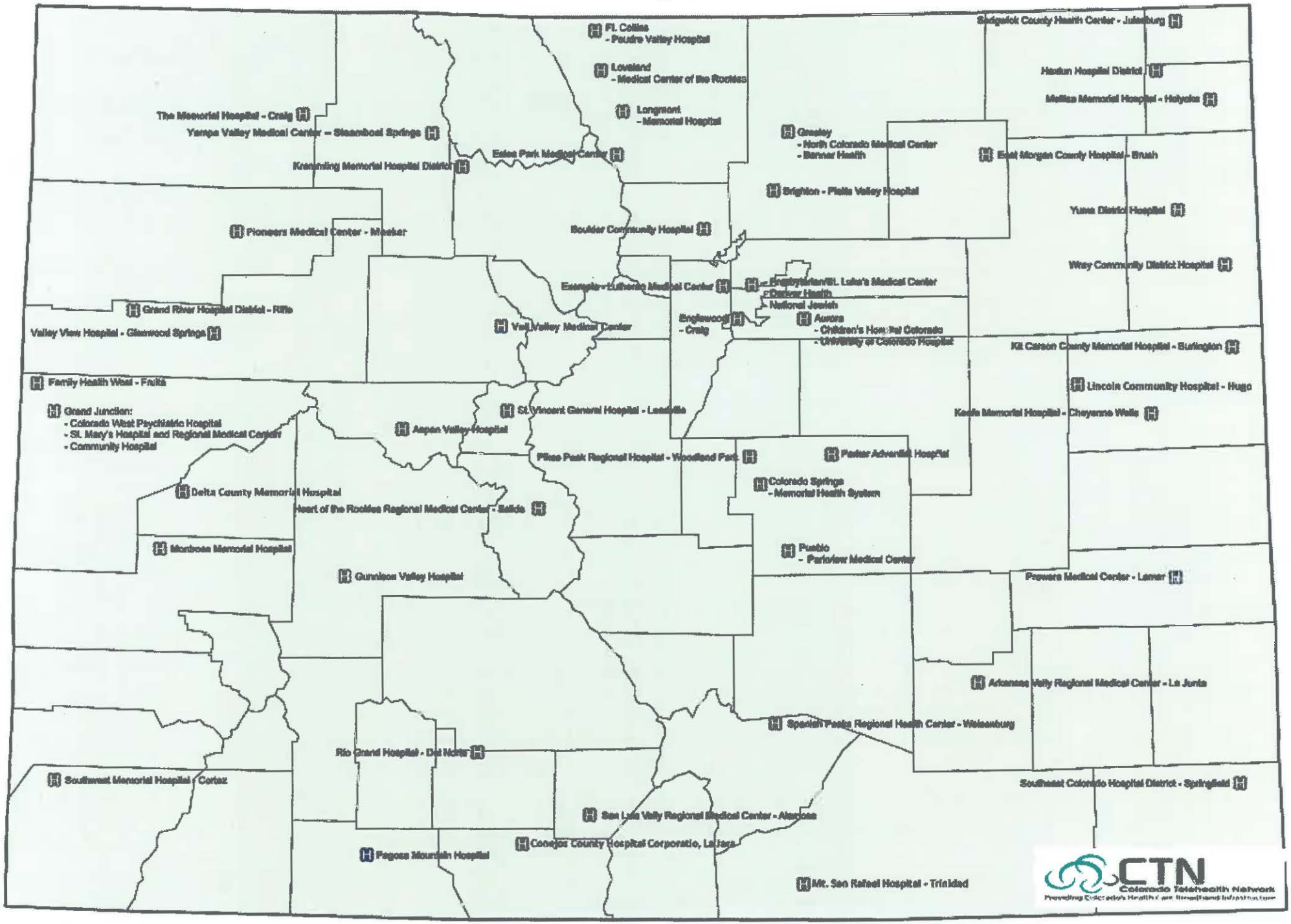
States of: CT, MA. RI, NH, VT & partial Maine
Total: 65,000 Square Miles

CTN
Colorado Telehealth Network

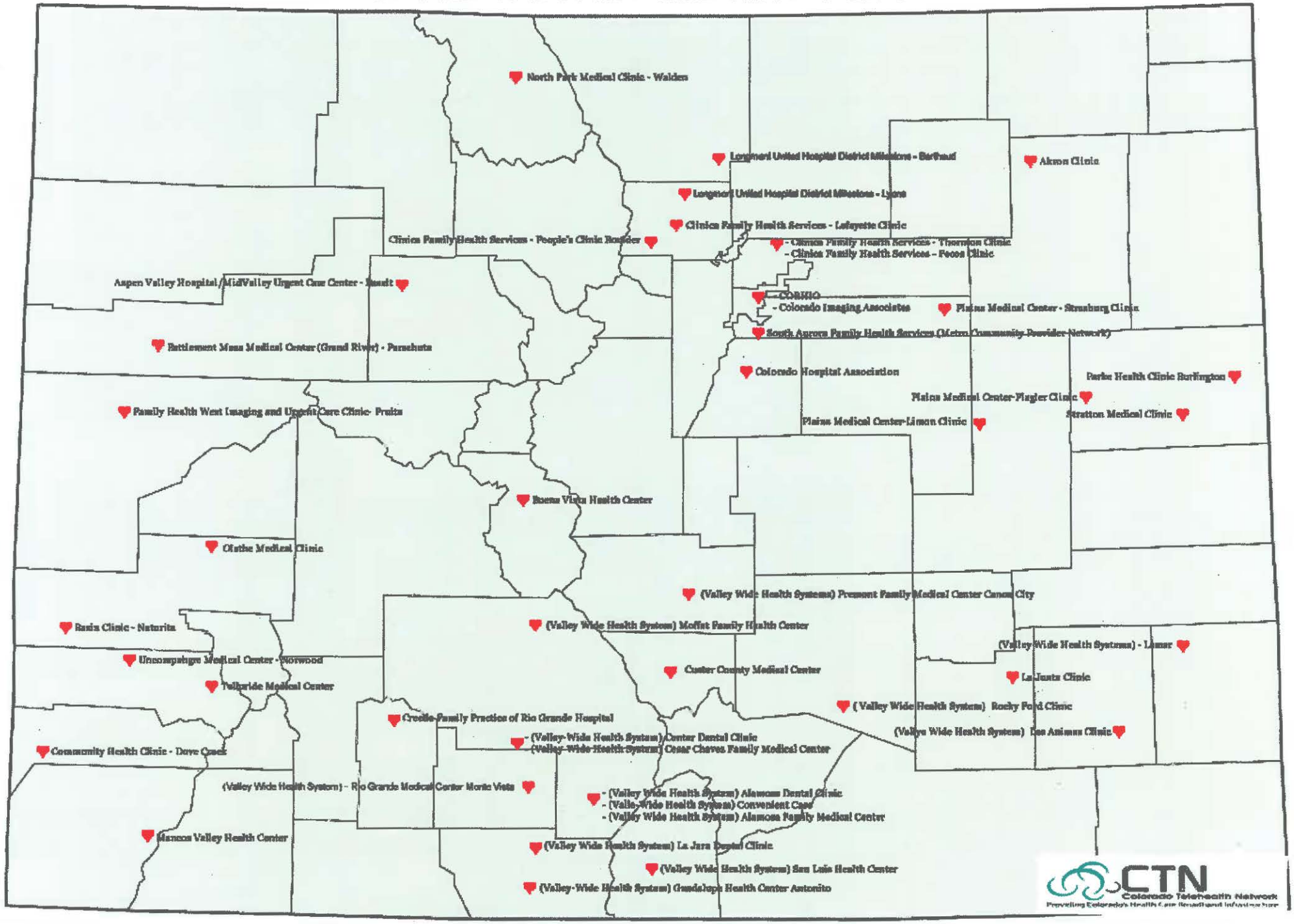
CTN Member Locations



CTN Hospitals



CTN Clinics & Other Health Care Providers



CTN Behaviorial Health Providers